DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/02/2012 FORM APPROVED OMB NO. 0938-0391

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
MAKE OF PROVIDER OR SUPPLIER BRECKENRIDGE HEALTH & REHABILITATION (A) 10 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00102305. Complaint IN00102305 - Unsubstantiated due to lack of evidence. Survey Dates: January 23, 24, 25, 26, 27 & 30, 2012 Facility Number: 100267010 Survey Team: Mary Weyls RN, TC (January 23, 24, 25, 26, & 30, 2012) Teresa Buske RN Debra Skinner RN Census Bed Type: SNF/NF: 41 NCC: 1 Total: 42 Census Payor Type: Medicare: 3 Medicaid: 35 Other: 4 Total 42 Stage 2 Sample: 31 Breckenridge Health & Rehabilitation was found			155468	B. WIN	G				
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		to be in compliance v	vith 42 CFR Part 483						

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	COMPLE	(X3) DATE SURVEY COMPLETED	
		155468 B. WING				C 01/30/2012	
	ROVIDER OR SUPPLIER	ABILITATION	\$	STREET ADDRESS, CITY, STATE, ZIP C 325 W NORTHWOOD DR SULLIVAN, IN 47882	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 000	Subpart B and 410 I/A Recertification and S the Investigation of C	e 1 AC 16.2 in regard to the tate Licensure Survey and complaint IN00102305. 2 by Suzanne Williams, RN	F 00)0			